STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345571	A. BUILDING _____ B. WING _____	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA BAY HEALTHCARE CTR OF WILMINGTON LLC	740 DIAMOND SHOALS ROAD WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to follow professional standards of nursing practice during dressing changes for 1 of 3 residents (Resident #26). The findings included: Resident #26 was admitted to the facility on 05/08/18 with cumulative diagnoses including stage 3 sacral pressure ulcer, Alzheimer's, fall at home with femur fracture, depression, anxiety, and dementia. Resident #26's Minimum Data Set (MDS) dated 05/22/18 revealed resident had severe cognitive impairments. The resident needed extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. Review of the Treatment Administration Record (TAR) revealed nursing did not initial off that Resident #26's dressing to his sacral pressure ulcer was changed on 06/05/18. A pressure ulcer dressing change observation for Resident #26 was conducted on 06/06/18 at 3:05 PM with Nurse #1 and the Director of Nursing (DON). The resident's existing stage 3 sacral pressure ulcer dressing was removed and observed not to be dated or initialed. In addition	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to follow professional standards of nursing practice during dressing changes for 1 of 3 residents. On 06/20/2018, the Director of Nursing audited the June Treatment Administration Records (TAR) for any blank spaces indicating the treatment was not signed off. 2. Procedure for implementing the acceptable plan of correction. On 06/21/2018, the Director of Nursing provided an in-service education to all full time, part time, and as needed nurses. Topics included: • Policy SWP-102 Daily wound	6/29/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/22/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 Nurse #1 did not date and initial the new dressing which she applied to the resident's sacrum. She also failed to check to initial the 06/6/18 dressing change on the resident's TAR. An interview was conducted on 06/06/18 at 3:10 PM with Nurse #1 who stated that before she worked for the facility she always dated and initialed all her dressing changes, which was good nursing practice. She said when she started at the facility, she was told that it was not the facility's policy to date and initial dressings, and was told to discontinue dating and initialing on dressings, and to only check off and initial on the TAR that a dressing was done. An interview was conducted on 06/07/18 at 4:30 PM with the Director of Nursing (DON), she confirmed that sacral dressing changes for Resident #26 were not checked off or initialed as completed on the resident's TAR for 06/5/18 and 06/6/18 per facility policy. However, after reviewing the facility's policy and procedure on dressing changes dated December 2014, she stated "moving forward" it was her expectation (per professional clinical practice) that all dressings were required to be dated and initialed when placed or changed, and that they were also to be documented on the residents' TAR's. An interview was conducted on 06/08/18 at 10:30 AM, and the facility's Administrator revealed it was her expectation per facility's policy and procedure on dressing changes dated December 2014, and per professional clinical practice, that all dressing changes were required to be dated and initialed when first placed or changed, as well as to also documented on the residents' TAR's.	F 658	documentation requirements. 1. Daily documentation should include an evaluation of the status of the dressing and if indicated the peri-wound areas and any complications. 2. This is documented on the TAR and initialed to indicate the dressing was checked and intact. If problems or complications then a full assessment of wound is documented on the Weekly Wound Review 3. Dressing changes and other treatments will be documented on the TAR. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the completion of wound documentation. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of all wound documentation on the TAR. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of	

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F 658	Continued From page 2	F 658	Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep cold salads made with mayonnaise at or below 41 degrees Fahrenheit prior to their leaving the kitchen. The facility also failed to air dry kitchenware before stacking it in storage, and failed to label and date opened food	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	6/29/18

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F 812	Continued From page 3 items. Findings included: 1. At 11:45 AM on 06/06/18 plastic wrap was placed over a cold plate containing three types of salads made with mayonnaise. At 11:47 AM on 06/06/18 the salad cold plate was placed on a tray, a tray slip was placed on the tray, and the tray was placed inside the meal cart. At 11:48 AM on 06/06/18 a calibrated thermometer used to check the temperature of the cold salads registered 51.4 degrees Fahrenheit for the tuna salad, 49.6 degrees Fahrenheit for the egg salad, and 48.7 degrees Fahrenheit for the chicken salad. At 11:50 AM on 06/06/18 a dietary employee reported when she checked the temperatures of the cold salads about an hour and half ago in the reach-in refrigerator they were at 40 degrees Fahrenheit. At 10:41 AM on 06/08/18 a dietary employee stated the facility made all its cold salads from scratch, and they could be held in refrigeration for 3 days (including the day they were made) before they were disposed of. She reported cold salads should be stored and leave the kitchen below 40 degrees Fahrenheit. She commented this practice helped reduce the chance that residents got sick from eating food served in the facility. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated the cold salads served on 06/06/18 contained a protein source (tuna, egg, or chicken), mayonnaise, and house seasonings. He reported these salads should be kept below 40 degrees Fahrenheit while they were stored in	F 812	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. Plan for correcting the specific deficiency. The process that led to deficiency cited. The facility failed to keep cold salads made with mayonnaise at or below 41 degrees Fahrenheit prior to their leaving the kitchen. The Director of Food & Nutrition on June 6, 2018, removed and discarded the composed salad made with mayonnaise. The remainder of the salads were then placed in an ice bin to remain under 41 degrees Fahrenheit. Dietary Staff was instructed to make composed salads with a minimum two hours prior to service to assure proper serving temperature. Temperatures of all foods (Cold and Hot) served on the Trayline are to be monitored and documented on the Trayline Temperature Log. Any foods not at appropriate temperature are either reheated or chilled to appropriate temperature prior to meal service. Dietary Management will monitor compliance with this policy during daily walk through to ensure that all food is served at the appropriate temperature. The facility failed to air dry kitchenware (tray pans) before stacking it in storage.	

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F 812	Continued From page 4 the kitchen. He commented cold salads made with mayonnaise were stored in the reach-in or walk-in refrigerators if they were made a day or so before serving, and they were placed in the walk-in freezer for a short time if they were made and served on the same day. 2. During initial tour of the kitchen, beginning at 11:37 AM on 06/04/18, 11 of 16 tray pans were stacked flush on top of one another with moisture trapped between them. During a follow-up tour of the kitchen, at 9:45 AM on 06/06/18 2 of 6 tray pans were stacked on top of one another with moisture trapped between them. At 10:41 AM on 06/08/18 a dietary employee stated she had received training about the storage of kitchenware. She reported the dietary staff was instructed to turn kitchenware upside down so it could drain and dry before stacking it on top of another in storage units. She commented trapped moisture could cause bacteria to grow. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated the dietary staff received training on storing kitchenware about two weeks ago, and at that time, staff were instructed that kitchenware had to be completely air dried before placing it in storage. 3. During initial tour of the kitchen and storage areas, beginning at 11:37 AM on 06/04/18, a box of pancake mix, a bag of rotini pasta, two bags of spaghetti noodles, 1 bag of ziti pasta, two bags of macaroni pasta, a package of creamy buttermilk dressing mix, and a 5-pound box of spice cake	F 812	The Director of Food and Nutrition completed rounds to ensure that all kitchenware was appropriately cleaned, sanitized and air dried prior to storage on June 6, 2018. All pans observed with condensation were rewashed and properly air dried. The facility failed to label and date opened food items. The Director of Food & Nutrition discarded the outdated items found and instructed the staff to check the remaining items in the store room to ensure proper labeling and dating procedures were being followed. 2. Procedure for implementing the acceptable plan of correction. An in-service on Preparing and Serving Cold TCS Food was conducted for all Dietary staff on June 7, 2018 by the Director of Food & Nutrition. An audit tool was put into place to monitor compliance with this policy on June 21, 2018. An in-service on Proper Warewashing was conducted for all Dietary staff on June 7, 2018 by the Director of Food & Nutrition & Nutrition. Dietary Management will ensure that staff will properly clean, sanitize and air dry all kitchenware prior to storage in cleaned and sanitized equipment storage areas. Daily walk through inspections will be performed by Dietary Management. An audit tool was put into place to monitor compliance with this policy on June 21, 2018.	

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F 812	Continued From page 5 mix in the dry storage room were opened, but without a label and date on them. In the walk-in freezer a bag of chicken fingers and a bag of diced chicken were opened, but were without a label and date on them. During a follow-up tour of the kitchen and storage areas, at 9:56 AM on 06/06/18, two fish filets, two bags of French fries, a bag of raspberries, and an angel food cake which were opened and found in the walk-in freezer were without labels and dates. At 10:41 AM on 06/08/18 a dietary employee stated it was the responsibility of all dietary employees to monitor storage areas daily as they went in and out of them to make sure that opened food items had labels and dates on them, and foods past their use-by dates were discarded. She reported this practice helped to avoid food spoilage, and ensured the quality of the food remained exceptional. At 10:50 AM on 06/08/18 the Food Service Director (FSD) stated all food items in storage should have a receive and open date on them. He reported the labeling and dating policy was posted in all storage areas. He commented all employees were expected to place labels and dates on food items when they opened them, but were unable to use them all, and had to place the remainder in storage. According to the FSD, this FIFO (first in, first out) policy helped make sure the freshest food possible was served to the residents.	F 812	An in-service on Proper Labeling and Dating was conducted for all Dietary Staff on June 7, 2018 by the Director of Food & Nutrition. Dietary Management will monitor food storage areas on daily walk through. An audit tool was put into place to monitor compliance with this policy on June 21, 2018. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Food & Nutrition or designee will monitor temperatures of cold TCS/PHF; the proper cleaning, sanitizing, air drying, and storage of kitchenware; and proper labeling and dating of opened food items in all food storage areas using the Dietary QA Audit Tool. This will be done 5 days per week, including weekend days, for two months and then weekly for one additional month. Reports will be presented to the weekly Quality Assurance meeting by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Committee. The weekly Quality Assurance Meeting is attended by The Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Director of Food & Nutrition. 4. The title of the person responsible for	

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F 812	Continued From page 6	F 812	implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		6/29/18

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F 842	Continued From page 7 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to keep complete and accurate medical records for 2 of 4 sampled residents (Resident #21 and #29) who had pressure ulcers.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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F 842	Continued From page 8 Findings included: 1. Resident #29 was admitted to the facility on 04/19/18. His documented diagnoses included pressure ulcers, diabetes, hypertension, and gout. A 04/19/18 Nursing Admission Review documented, "Pressure ulcer on top of right foot is 1/2 inch x 1 1/2 inches. Side of right foot if 2 inches x l inch." On 4/19/18 three electronic Weekly Wound Reviews were created. One documented, "no wounds noted." The other two reviews documented Resident #29 had pressure ulcers to the right heel, side of the right foot, left heel, and top of the left foot. The resident's 04/26/18 admission minimum data set (MDS) documented his cognition was moderately impaired, he exhibited no behaviors including resistance to care, he required anywhere from minimal to extensive assistance from staff with his activities of daily living, he was always continent of bladder and occasionally incontinent of bowel, his weight was stable, and he had 3 unstageable ulcers present on admission. The 04/27/18 Weekly Clinical handwritten assessment for Resident #29's four ulcers included measurements and type of tissue in the wound bed. However, this assessment did not include information about the percentage of different types of tissue in the wound bed, exudate, odor, or pain. The 05/02/18 handwritten Weekly Clinical	F 842	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to keep complete and accurate medical records for 2 of 4 sampled residents who had pressure ulcers. On 06/21/2018, the Director of Nursing audited all current residents who have a pressure ulcer to ensure wound documentation utilizing the weekly pressure ulcer wound UDA was completed for each identified pressure ulcer at least every 7 days and was complete. 2. Procedure for implementing the acceptable plan of correction. On 06/22/2018, the Director of Nursing provided an in-service education to all full time, part time, and as needed nurses. Topics included: • Initiating a progress note for all newly identified in-house developed pressure ulcers and pressure ulcers noted on admission. • Documentation requirements for new wound in facility or on admission. On 06/21/2018, the Nurse Consultant provided an in-service education to management nurses (Director of Nursing, Assistant Unit Manager, and the Staff	

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F 842	Continued From page 9 assessment and the 05/02/18 electronic Weekly Pressure Ulcer Review were the first documents to capture measurements, wound tissue and the percent of that tissue, exudate, odor, and pain on all four of Resident #29's wounds. There was no 05/09/19 assessment of Resident's 29's wounds either in a handwritten or electronic format. At 12:20 PM on 06/07/18 the Director of Nursing (DON) stated Nurse #2 measured and assessed resident wounds on 05/09/18, but forgot to document the information. The resident's treatment administration record (TAR) documented on 05/25/16 the resident began receiving the sacral wound treatment of hydrogel covered with a dry dressing daily for a stage II sacral pressure ulcer. A 05/26/18 Skilled Nursing Review progress note documented Resident #29 now had a pressure ulcer to his sacrum as well as pre-existing ulcers to his right heel, the top and side of his right foot, and his left heel. "Air mattress ordered, awaiting delivery." A 06/01/18 handwritten Weekly Clinical assessment included the first measurements and wound bed description of Resident #29's sacral ulcer. There was no 06/01/19 electronic Weekly Pressure Ulcer Review completed on the resident's sacral ulcer so there was still no information provided about the percent of different types of tissue in the wound bed, exudate, odor, or pain associated with the ulcer. Observation on 06/06/18 at 8:38 AM revealed	F 842	Development Coordinator). Topics included: • At least every 7 days, all pressure ulcer wounds are assessed and the weekly pressure ulcer wound UDA is completed. • How to complete a weekly wound pressure ulcer wound UDA. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor the completion of weekly pressure ulcer wound documentation. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing 100% of all pressure ulcers for wound documentation at least every 7 days in the weekly pressure ulcer wound UDA. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 10 there was only a regular/standard mattress on Resident #29's bed. However, starting on 05/25/18 on the medication administration record (MAR) nursing was initialing off that they observed that the resident's air mattress was properly inflated. On 06/06/18 at 4:55 PM Nurse #2 stated Resident #2 felt the air mattress was uncomfortable, and did not want it to remain in place. She reported the resident made this decision after sleeping on it for two night. Resident #29's care plan, last revised on 06/06/18, identified, "I currently have (pressure ulcers) and potential for (future) pressure ulcer development r/t (in regard to) immobility" as a problem. On 06/07/18 at 5:00 PM the DON stated weekly wound assessments should include type of wounds, location of wounds, stage of pressure wounds, type and percent of tissue in wound beds, drainage/exudate information, and information about odor and pain associated with the wounds. She reported official assessment and measurement of wounds took place every Wednesday, but she still expected the nurses who initially viewed a newly emerged pressure ulcer to document approximate size, location, general description of wound bed, and presence of any drainage and odor. On 06/08/18 at 10:56 AM the Administrator stated an air mattress did not have to be ordered for Resident #29 because there was one already in the facility that was not in use. She reported two staff members told her the resident allowed it on his bed two nights before requesting that it be	F 842	Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	

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	345571	A. BUILDING _____ B. WING _____	06/08/2018

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F 842	Continued From page 11	F 842		

removed. She commented staff should observe or administer something before initialing off on the MAR or TAR that the task was completed. According to the Administrator, corrective action was being taken against the nurses who had been incorrectly initialing off that Resident #29's air mattress was inflated correctly.

2. Resident #21 was admitted to skilled nursing on 03/30/18, discharged to assisted living on 05/22/18, and readmitted to skilled nursing on 06/01/18. The resident's documented diagnoses included pressure ulcer, osteoarthritis, peripheral vascular disease, and iron-deficiency anemia.

A 04/20/18 Weekly Skin Check documented Resident #21 had a new pressure ulcer.

It was not until completion of the 04/23/18 electronic Weekly Pressure Ulcer Review that the location and complete description of the wound was captured in an assessment.

An electronic Weekly Pressure Ulcer Review was completed for Resident #21's sacral pressure ulcer on 05/02/18.

The resident's 05/8/18 significant change minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required anywhere from minimal to extensive assistance with her activities of daily living, she was occasionally incontinent of bowel and bladder, she experienced significant weight loss, and she had one unstageable pressue ulcer which presented with slough or eschar in the wound bed.

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F 842	Continued From page 12 There was no 05/09/19 assessment of Resident's 21's ulcer either in a handwritten or electronic format. At 12:20 PM on 06/07/18 the Director of Nursing (DON) stated Nurse #2 measured and assessed resident wounds on 05/09/18, but forgot to document the information. The resident's care plan, last updated 6/1/18, identified, "I currently have a pressure ulcer to my sacrum /potential for (future) pressure ulcer development" as a problem. On 06/07/18 at 5:00 PM the DON stated weekly wound assessments should include type of wounds, location of wounds, stage of pressure wounds, type and percent of tissue in wound beds, drainage/exudate information, and information about odor and pain associated with the wounds. She reported official assessment and measurement of wounds took place every Wednesday, but she still expected the nurses who initially viewed a newly emerged pressure ulcer to document approximate size, location, general description of wound bed, and presence of any drainage and odor.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		6/29/18

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F 880	Continued From page 13 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 14 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility staff failed to dispose of a gown and gloves properly for one of two residents on contact isolation (Resident #17). Findings included: A review of the facility's in-service records revealed the housekeeping staff were in-serviced on infection control on 04/18/18 at 12:00 PM. Resident #17 was admitted to the facility on 06/05/18. Resident #17's diagnosis included Extended Spectrum Beta-Lactamases (ESBL) in her urine, urinary tract infection (UTI), E-coli, dementia, Alzheimer's, and major depression. A review of Resident #17's care plan dated 06/5/18 revealed the resident was on antibiotic therapy with risk of adverse therapy related to	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F880 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to dispose of a gown and gloves properly for 1 of 2 residents on contact isolations. On 06/21/2018, the Staff Development Coordinator completed infection control	

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F 880	Continued From page 15 E-coli, and had ESBL UTI and required contact isolation. Interventions included: wear gloves and mask when changing contaminated linen, place soiled linens in bags marked biohazard, bag linens, and close bag tightly before taking to laundry. An observation of Resident #17's room on 06/06/18 at 9:08 AM revealed PPE (Personal Protective Equipment) was available outside Resident #17's door in a closed cart, there were two red hazardous waste cans located just inside the resident's room next to the door, and a contact precaution sign was posted on the resident's door. An observation on 06/06/18 at 9:10 AM revealed Housekeeper #1 exiting Resident #17's room gowned and gloved. The housekeeper stood outside the resident's room with the gown balled up in her hands. She went to a large black garbage can located in the hall and disposed of the gown and gloves. In an interview on 06/06/18 at 09:15 AM Housekeeper #1 stated she did not know why she disposed of her gown and gloves in the black garbage can in the hallway rather than in the red hazardous waste bins located inside the resident's room. An interview on 06/6/18 at 9:20 AM Nurse #2 stated Resident #17 was on contact precautions for ESBL in her urine. She said it was her expectation that PPE should be removed prior to exiting the resident's room and disposed of in the red hazardous waste bins located just inside the resident's room. She stated the staff just had an in-service on isolation precautions months ago.	F 880	rounds to observe staff entering and exiting resident rooms who are on isolation precautions. The staff were audited for donning PPE prior to entering the room and doffing the PPE prior to exiting the room and the PPE was properly disposed. 2. Procedure for implementing the acceptable plan of correction. On 06/06/2018 and 06/22/2018, the Staff Development Coordinator provided an in-service education to all full time, part time, and as needed nurses, CNA's, Med Tech's, House Keeping Staff, Dietary Staff, Maintenance Staff, and Department Manager staff. Topics included: • Donning PPE prior to entering a resident room that is on isolation precautions. • Doffing the PPE prior to exiting the resident's room and how to properly dispose of the PPE. • Hand hygiene after exiting the isolation room. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor the correct disposal of PPE when exiting a resident room on	

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F 880	Continued From page 16 An interview with the Director of Nursing (DON) was conducted on 06/06/18 at 9:40 AM. The DON reported that it was her expectation when a resident was on contact precautions that the staff would place a precaution sign on the door and have a PPE cart outside the resident's room. The DON reported it was her expectation that all staff would glove and gown when providing care to the resident prior to entering the room. She reported it was her expectation that when the staff was finished providing care that they would remove the gown and gloves and dispose of them in the red hazardous bins located in the room and wash hands with soap and water prior to leaving the room. The DON reported it was her expectation that the staff follow any precautions that the residents were on. The DON reported all staff were in-serviced on infection control practices during orientation and yearly. An interview with the Administrator was conducted on 06/08/18 at 10:56 AM. The Administrator reported it was her expectation that if a resident was on infection precautions, the staff would follow those precautions.	F 880	isolation precautions. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 2 months. Monitoring will include auditing for the correct disposal of PPE upon exiting the resident's room on isolation precautions. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	